DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445207 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 12/13/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEXFORD HOUSE, THE | 2421 JOHN B DENNIS HIGHWAY<br>KINGSPORT, TN 37660 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 021 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:<br><br>a) the required manual fire alarm system;<br><br>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br><br>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure corridor fire doors were held open by approved devices.<br>The findings include:<br>Observation and interview with the Maintenance Director, on December 14, 2010 at 2:00 p.m. confirmed the kitchen fire door to the service corridor was not provided with a latching mechanism and failed to close to a positive latch. | K 021 | 1. The fire door to the kitchen from the service corridor was promptly provided with a latching mechanism that closes to a positive latch.<br>2. All other fire doors were promptly checked to ensure that they have a latching mechanism that closes the door to a positive latch.<br>3. A systematic approach for ensuring that all fire doors that should have a latching mechanism that closes the door to a positive latch be repaired by the following: notification of environmental services mgr when a door has been identified, promptly repairing the door with the appropriate latching mechanism to ensure a positive latch, and maintaining information of the check and repair in a category on the Fire Door Log.<br>4. Monitoring of all fire doors to ensure they have a latching mechanism that closes the door to a positive latch be will kept in a separate category on the Fire Door Check Log, which will be updated and monitored monthly by the Environmental Service Staff. | 1/30/11 |
| K 029 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system | K 029 | 1. The unsealed penetration in the number 1 and 400 hall electrical ceilings, behind the dryers, and in the "Lochinvar" boiler room ceiling and back wall have been repaired with a<br><br>Continued... | 1/30/11 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 12/22/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 029 | Continued From page 1<br>option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure hazardous area ' s one (1) hour fire rated construction is maintained.<br>The findings include:<br>Observation and interview with the Maintenance Director, on December 14, 2010 at 2:00 p.m. confirmed unsealed penetrations in the number 1 and 400 hall electrical room ceilings, behind the dryers, and in the "Lochinvar" boiler room ceiling and back wall. | K 029 | Continued...<br><br>smoke barrier fire rating caulking (CP25-WB).<br><br>2. Any other penetration that is created in the wall or ceiling for the purpose of computer lines, etc. will be promptly repaired with a smoke barrier fire caulking.<br>3. A systematic approach for repairing any penetration in the integrity of the ceiling or walls will be repaired by the following: notification of environmental services when a penetration is necessary, promptly repairing the penetration post the job, and maintaining information of the penetration and repair on a Fire Retardant Log.<br>4. Monitoring of all ceiling and wall penetrations will be will be kept on a Fire Retardant Log as they occur. The log will be updated and monitored monthly by the Environmental Service Staff. | 1/30/11 |
| K 038 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1; 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure exterior sidewalks were provided with a clear path to a public way.<br>Observation and interview with the Maintenance Director, on December 14, 2010 at 12:00 p.m. and at 2:40 pm confirmed the exit from the 500 hall exit, exit by medical records and exit from the | K 038 | K 038<br><br>1. The exit from 500 hall (exit by medical records) and the exit from the small dining room were cleared of snow and ice promptly after being identified by the surveyor on 12/14/10<br>2. All other exterior sidewalks will be promptly cleared of snow and ice during inclement weather by shoveling or scraping then applying a melting product such as salt<br>3. A systematic approach for assuring the clearing of snow and ice on<br><br>Continued... | 1/30/11 |

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| K 038 | Continued From page 2<br>small dining room were not clear of snow and ice. | K 038 | Continued...<br><br>exterior sidewalks will be accomplished by notifying environmental services when snow and/or ice are present on the sidewalks, promptly scraping it away then salting the affected area, then maintaining the information of the clearing on a "Snow/Ice Removal Log."<br>4. Monitoring of all snow and/or ice covered sidewalks will be kept on a Snow/Ice Removal Log as inclement weather occurs. The log will be updated and monitored monthly by the Environmental Service Staff. | 1/30/11 |